Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of diabetes**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

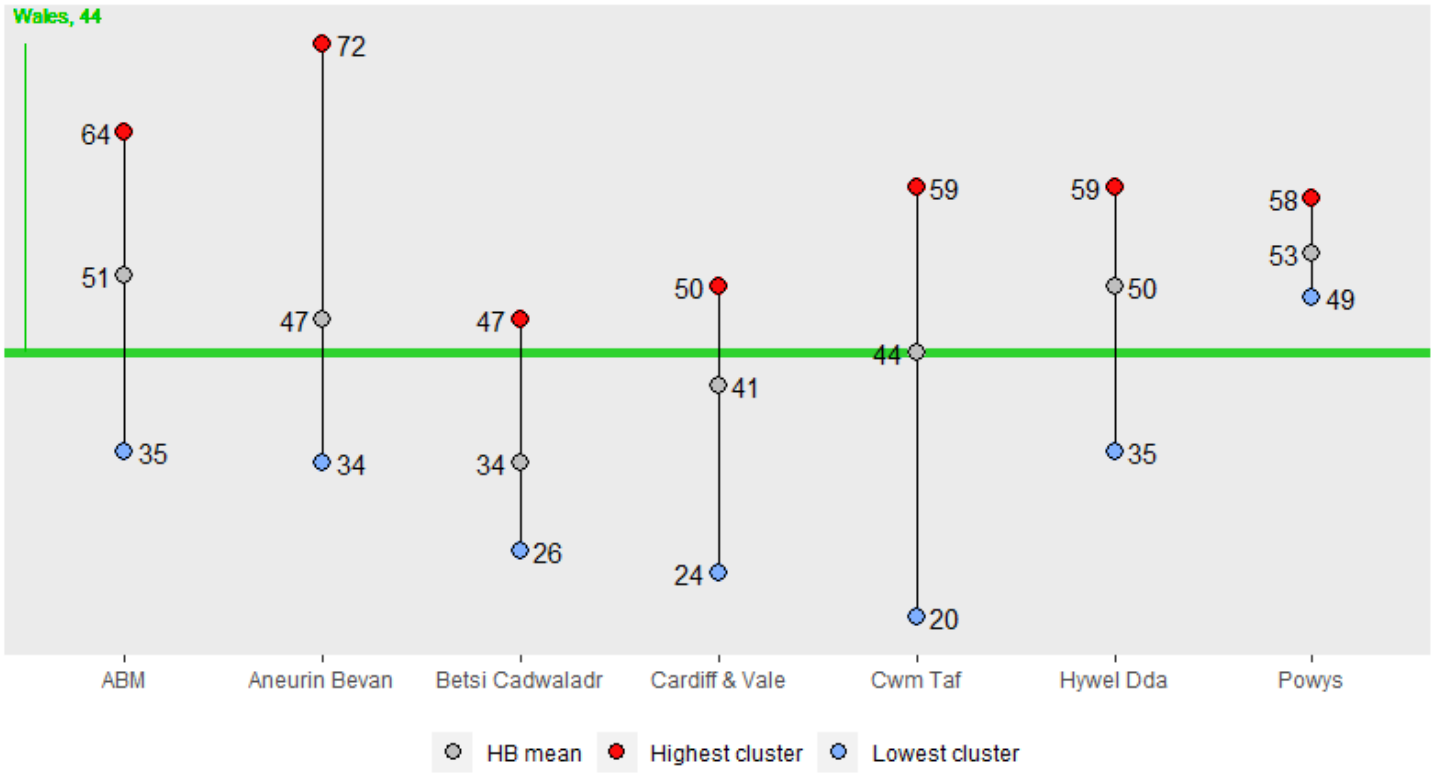
ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- About 57% of the DALYs due to diabetes, urogenital, blood and endocrine diseases are attributable to known risk factors (*Health and its determinants in Wales*; PHW 2018; link).
- During the period from 2003/04 to 2015 the prevalence of self-reported treatment for diabetes in Wales has risen (*Health and its determinants in Wales*; PHW 2018; link); this underpins the importance of prevention efforts.
- Key policy on diabetes is set out in the *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link).
- Indicators for this topic are reported via Primary Care Measures.

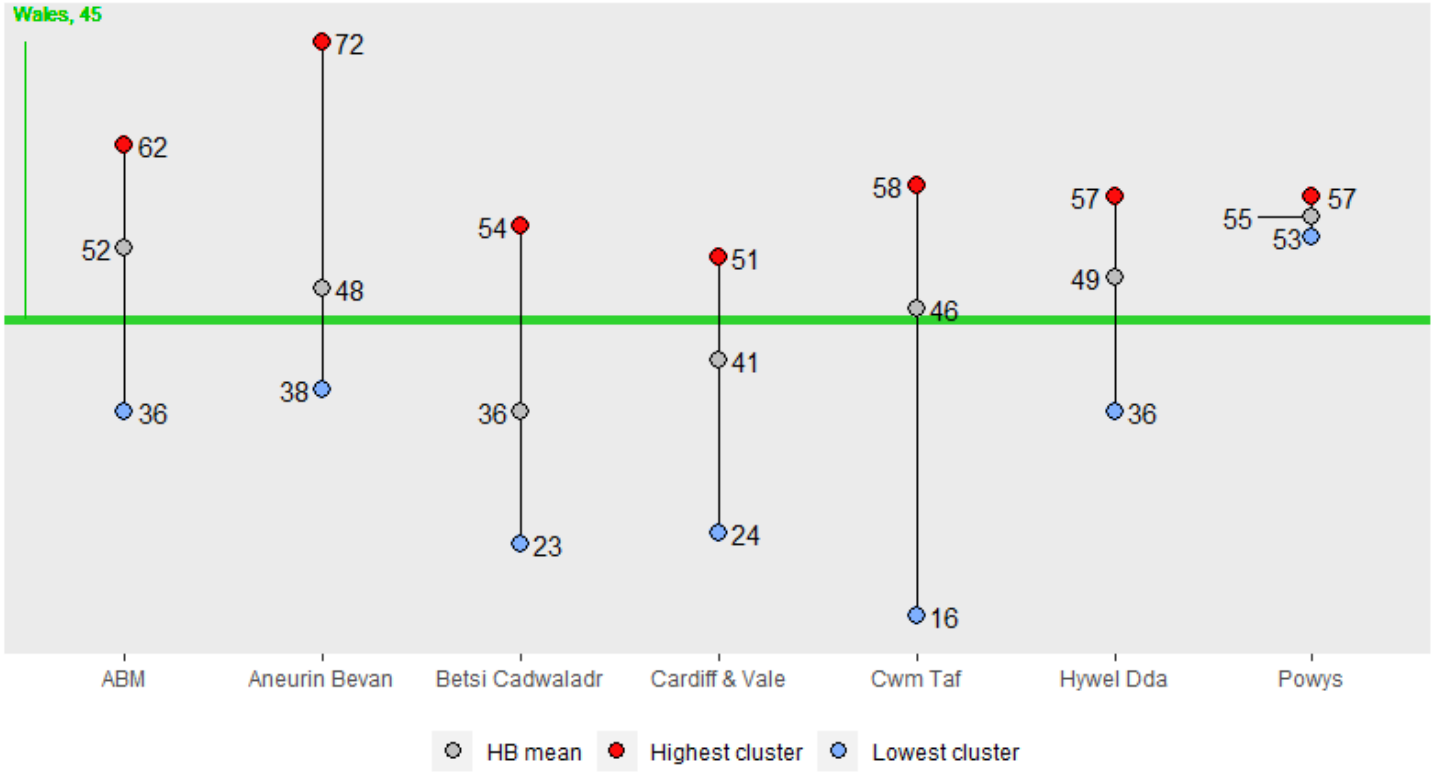
▼ PCM national variation

ⓘ Primary Care Measures (PCM) are a set of care quality indicators for primary care in Wales. The charts below emphasise variation between and within health boards; for further information see here. Beneath the charts are improvement action options that may inform cluster IMTPs. Variation is a natural phenomenon and can be healthy e.g. it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes. Variation that is observed in a healthcare context may be referred to as *inequality*; inequality that is judged to be both avoidable and socially unjust is termed *inequity* (sometimes alternatively described as *unwarranted variation*).

Variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by cluster within each health board, 2017/18 (*Source*: PCIP, Nov 2019):



Variation in proportion of people with diabetes who have received all National Diabetes Audit key care processes, by cluster within each health board, 2016/17 (*Source*: PCIP, Nov 2019):



▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.

- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.

▼ ⓘ Tell me about: Prevention

Definitions:

- Zola's river analogy is a useful way of thinking about prevention of ill health (Zola 1970). It describes **primary** prevention (stopping everyone from falling into a river and coming to harm e.g. never smoking), **secondary** prevention (ensuring any individuals at risk who do fall in get to safety quickly; minimising the chance of complications through early identification and intervention e.g. screening) and **tertiary** prevention (search-and-rescue for those taken downstream; mitigating the worst consequences of established disease e.g. vascular surgery).
- The Welsh Government definition of prevention is broader: working in **partnership** to co-produce the best outcomes possible, utilising the strengths and **assets** people and places have to contribute.

Building a healthier Wales (Feb 2019) sets out six key principles for implementing prevention in Wales:

- Adhere to the **five ways** of working (as outlined in the Well-being of Future Generation Act).
- Commit to investing in **evidence-based** interventions (where available or evaluate small and scale up if appropriate).
- Ensure evidence-based interventions have sufficient **scale** and **reach** to make a measurable population impact and to reduce inequalities.
- Ensure services are provided to a sufficient **quality** to achieve the best possible **outcomes** for each intervention; continually improve by drawing upon quality improvement techniques.
- Balance intervention benefits for **short and long-term** outcomes (including investing in one sector to realise a return in another).
- Optimise **value** by taking an agile approach to evaluating interventions and approaches and disinvesting in those that do not yield benefit/ value.

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Modify behavioural risk factors to prevent diabetes or limit disease progression**

- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).
- The importance of reducing these behavioural risk factors is reiterated in the *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link).
- NICE cite evidence that for people with impaired glucose tolerance, dietary and exercise interventions can halve the number progressing to type 2 diabetes (link).

▼ Modify clinical risk factors to prevent diabetes or limit disease progression

- Optimise primary/ secondary preventive actions for high body mass index (childhood [CRF-002] and adult [CRF-003] obesity).
- The importance of reducing obesity is reiterated in the *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link). Of particular relevance to primary care clinicians, the plan recommends implementation of the Wales Obesity Pathway at all levels, for both adults and children.
- The secondary prevention importance of lowering blood pressure (CRF-001) and reducing other risk factors for cardiovascular disease (e.g. high cholesterol [see NICE CG181]) among those with diabetes is noted in NICE guidance (link; see below).

▼ Encourage uptake of vaccination against influenza to reduce comorbidity

- Optimise uptake of influenza vaccination (IDP-001).
- Diabetes increases the risk of influenza-related complications (e.g. pneumonia), with an increased risk of hospitalisation and mortality (BMJ 2013; 347: f5061).
- People aged six months to less than 65 years with diabetes were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ Focus on improving detection of diabetes

- Increased ascertainment of those at risk, with confirmation of a diagnosis of diabetes, will affect prevalence proportion. Higher cluster prevalence may reflect one or more of higher population disease prevalence; opportunity to improve delivery of behaviour change interventions; opportunity to improve identification and/ or management of clinical risk factors; access to health care; or the effectiveness of case finding.
- For signposting to relevant NICE guidelines/ quality standards relating to detection of diabetes as a source of potential improvement actions, see below.
- The *Diabetes delivery plan for Wales 2016–2020*(WG 2016; link) suggests local modelling of expected diabetes prevalence (see POP-001) to evaluate any ascertainment gap and advocates the development of educational tools for healthcare professionals to support the detection and classification of diabetes.

▼ **Focus on improving management of diabetes to effect remission or limit progression**

- Improving the quality of diabetes care is unlikely to lower measured prevalence, even via improvement in insulin sensitivity to effect temporary or partial remission of type 2 diabetes. Although NICE indicate remission through intensive lifestyle interventions or bariatric surgery is possible (link), it is unclear that this scenario would result in clinical revocation of a diabetes diagnosis, due to the risk of relapse (see also Diabetes UK position statement; link).

- Whether type 2 diabetes is remissible or not, improved care quality may reduce the risk of complications/ future events; improve quality of life for the patient and their carers/ families; reduce inequity in health outcomes; or reduce (or increase) health and social care utilisation and costs.

- Indicator review for condition management (e.g. successful reduction of HbA1c) is not included in the initial release of the PCNA tool; this is subject to improvements in PHW access to primary care data that would inform actionable intelligence.

- Audit concordance across the cluster against receipt of all nine NICE key care processes as part of the National Diabetes Audit (link); this may be supported by the RCGP *Quality improvement toolkit for diabetes care* (link).

- For signposting to relevant NICE guidelines/ quality standards relating to secondary prevention of diabetes as a source of potential improvement actions, see below.

▼ **Ensure awareness and implementation of NICE guidance/ quality standards**

- *Type 2 diabetes prevention: population and community-level interventions*. Public health guideline [PH35] (Published date: May 2011) includes recommendations suitable for adoption by healthcare professionals. This guideline covers preventing type 2 diabetes in adult populations and communities who are at high risk. It aims to promote a healthy diet and physical activity at community and population level, and recommends how to tailor services for people in ethnic communities and other groups who are particularly at risk of type 2 diabetes.

- *Type 2 diabetes: prevention in people at high risk*. Public health guideline [PH38] (Published date: July 2012; Last updated: September 2017) includes recommendations suitable for adoption by healthcare professionals. This guideline covers how to identify adults at high risk of type 2 diabetes. It aims to remind practitioners that age is no barrier to being at high risk of, or developing, the condition. It also aims to help them provide those at high risk with an effective and appropriate intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.

- *Type 1 diabetes in adults: diagnosis and management*. NICE guideline [NG17] (Published date: August 2015; Last updated: July 2016) includes recommendations suitable for adoption by healthcare professionals. This guideline covers the care and treatment of adults (aged 18 and over) with type 1 diabetes.

- *Diabetes (type 1 and type 2) in children and young people: diagnosis and management*. NICE guideline [NG18] (Published date: August 2015; Last updated: November 2016) includes recommendations suitable for adoption by healthcare professionals. This guideline covers the diagnosis and management of type 1 and type 2 diabetes in children and young people aged under 18. The guideline recommends strict targets for blood glucose control to reduce the long-term risks associated with diabetes.

- *Type 2 diabetes in adults: management*. NICE guideline [NG28] (Published date: December 2015;

Last updated: May 2017) includes recommendations suitable for adoption by healthcare professionals. This guideline covers the care and management of type 2 diabetes in adults (aged 18 and over). It focuses on patient education, dietary advice, managing cardiovascular risk, managing blood glucose levels, and identifying and managing long-term complications.

- *Diabetes in adults*. Quality standard [QS6] (Published date: March 2011; Last updated: August 2016) sets out seven quality statements, any of which could form a focus for collective local improvement action. This quality standard covers care and treatment for adults with diabetes. It includes preventing type 2 diabetes, managing type 1 and type 2 diabetes, diabetes-related foot care and diabetes education programmes. It describes high-quality care in priority areas for improvement.

- *Diabetes in children and young people*. Quality standard [QS125] (Published date: July 2016) sets out six quality statements, any of which could form a focus for collective local improvement action. This quality standard covers diagnosing and managing type 1 and type 2 diabetes in children and young people (under 18). It describes high-quality care in priority areas for improvement.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent diabetes or limit disease progression

- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

- The importance of reducing these behavioural risk factors is reiterated in the *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link).

- NICE cite evidence that for people with impaired glucose tolerance, dietary and exercise interventions can halve the number progressing to type 2 diabetes (link).

▼ Modify clinical risk factors to prevent diabetes or limit disease progression

- Optimise primary/ secondary preventive actions for high body mass index (childhood [CRF-002] and adult [CRF-003] obesity).

- The importance of reducing obesity is reiterated in the *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link). Of particular relevance to primary care clinicians, the plan recommends implementation of the Wales Obesity Pathway at all levels, for both adults and children.

▼ Encourage uptake of vaccination against influenza to reduce comorbidity

- Optimise uptake of influenza vaccination (IDP-001).
- Diabetes increases the risk of influenza-related complications (e.g. pneumonia), with an increased risk of hospitalisation and mortality (BMJ 2013; 347: f5061).
- People aged six months to less than 65 years with diabetes were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ **Focus on improving detection of diabetes**

- The *Diabetes delivery plan for Wales 2016–2020* (WG 2016; link) advocates opportunistic risk assessment and testing in areas such as community pharmacies.

▼ **Ensure awareness and implementation of NICE guidance**

- *Type 2 diabetes prevention: population and community-level interventions*. Public health guideline [PH35] (Published date: May 2011) includes recommendations suitable for adoption by healthcare professionals. This guideline covers preventing type 2 diabetes in adult populations and communities who are at high risk. It aims to promote a healthy diet and physical activity at community and population level, and recommends how to tailor services for people in ethnic communities and other groups who are particularly at risk of type 2 diabetes.
- *Type 2 diabetes: prevention in people at high risk*. Public health guideline [PH38] (Published date: July 2012; Last updated: September 2017) includes recommendations suitable for adoption by healthcare professionals. This guideline covers how to identify adults at high risk of type 2 diabetes. It aims to remind practitioners that age is no barrier to being at high risk of, or developing, the condition. It also aims to help them provide those at high risk with an effective and appropriate intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.
- *Community pharmacies: promoting health and wellbeing*. NICE guideline [NG102] (Published date: August 2018) includes recommendations suitable for a broad audience. This guideline covers how community pharmacies can help maintain and improve people's physical and mental health and wellbeing, including people with a long-term condition. It aims to encourage more people to use community pharmacies by integrating them within existing health and care pathways and ensuring they offer standard services and a consistent approach. It requires a collaborative approach from individual pharmacies and their representatives, local authorities and other commissioners.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Working with a Community Diabetic Dietician**

- *What problem was being addressed?* Need to improve patient confidence to self-manage diabetes and staff confidence in advising people with diabetes.

- *What was done to address it?* The Cluster team liaised with the BCUHB Diabetic team, as we felt that there was a need for a Community Diabetic ANP in the area and supported the role by funding additional sessions for the Community Diabetic Dietician for the area, who provides educational sessions such as the X-PERT course. We are now in the first year of the development of the post, and have been collecting data, which is currently being collated. The ANP supports primary care nursing staff with education on diabetes, as well as conducting joint clinics in the community with GPs and Practice nurses, for complicated diabetic patients, and the feedback from the team has been very positive.

- *Who did it or who can be contacted in the event of queries?* Arfon cluster (Dr Nia Hughes; Ellen Williams; Helen Williams).

- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ Employing a Diabetes Specialist Nurse

- *What problem was being addressed?* Need to improve patient confidence to self-manage diabetes and staff confidence in advising people with diabetes.

- *What was done to address it?* Following consultation with the Diabetes secondary care team, the cluster invested in a Diabetes specialist nurse to provide patients with education encouraging self-management of their condition, to provide training to clinical staff in practices, and provide advice and guidance to care/ nursing homes.

- *Who did it or who can be contacted in the event of queries?* Conwy West cluster (Geraint Davies; Cath Hughes; Jodie Berrington; Sallie France; Bernadette Jones).

- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ Establish a Diabetes Community Clinic

- *What problem was being addressed?* Need to ensure diabetes care close to home.

- *What was done to address it?* Supported the development of intermediate clinics and support groups in the form of a Diabetes Community Clinic, delivering services closer to home, reducing wait times and improving patient experience and outcomes.

- *Who did it or who can be contacted in the event of queries?* North Cynon cluster (Dr Owen Thomas; Hayley Rogers; Angharad Pitt) and South Cynon cluster (Dr Simon Gray; Lynwen Francis; Angharad Pitt).

- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ Placeholder project description

- *What problem was being addressed?* Placeholder.

- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

Type here...

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here...

Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

Type here

What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.